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THIS IS A PUBLIC HEALTH EMERGENCY AND WOULD SIGNIFY A BIOTERRORISM EVENT.

Smallpox (Variola)

Overview^(1,2,3,4)

Smallpox was declared globally eradicated in 1980, but remains a potential bioterrorism weapon. If you suspect that you are dealing with a bioterrorism situation, immediately contact your [Senior Epidemiology Specialist for the region](#), or the Department of Health and Senior Service's Situation Room (DSR) at 800-392-0272.

Smallpox is a serious, contagious, and frequently fatal systemic viral disease that usually presents with a characteristic skin rash. There is no specific treatment for smallpox disease, and the only prevention is vaccination, and the isolation / quarantine of cases and contacts.


There are two clinical forms of smallpox.

- Variola major is the severe and most common form of smallpox, with a more extensive rash and higher fever. There are four epidemiologically significant types of variola major smallpox: ordinary (the most frequent type, accounting for 90% or more of cases); modified (mild and occurring in previously vaccinated persons); flat, and hemorrhagic (both rare and very severe). Historically, variola major has an overall fatality rate of about 30%; however, flat and hemorrhagic smallpox usually are fatal.
- Variola minor is a less common presentation of smallpox, and a much less severe disease with death rates historically of 1% or less.

Transmission of variola normally occurs by inhalation of virus-containing large airborne droplets of saliva from an infected person. Generally, direct and fairly prolonged face-to-face contact is required to spread smallpox from one person to another. The risk of developing smallpox increases with close contact (6.5 feet or less), increasing length of exposure to a case, and the stage and severity of clinical illness in the person to whom one is exposed (e.g., the risk is increased if the patient has a rash and/or cough). Smallpox also can be spread through direct contact with infectious bodily fluids, crusted scabs, or contaminated objects such as bedding, or clothing, however, these methods are less efficient than spread via droplets. Rarely, indirect spread (not requiring face-to-face contact) via fine-particle aerosols in enclosed settings has been reported. During the smallpox era, the disease had secondary attack rates of up to 80% for close or household contacts.

Humans are the only natural hosts of variola. Smallpox is not known to be transmitted by insects or animals. Death was generally attributed to an overwhelming viremia. In fatal cases, death usually occurred between the tenth and sixteenth day of illness.⁽⁴⁾

Incubation period is from 7 to 17 days, commonly 12 – 14 days to onset of prodromal illness, and 2-4 days more to decrease in fever and onset of rash. Onset of the prodromal illness is sudden, with fever, malaise, headache, prostration, severe backache and occasional abdominal pain and vomiting.

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Period of communicability is from the time of development of the earliest lesions to the disappearance of all scabs, about 3 weeks. The earliest lesions are commonly found in the mouth and pharynx. Transmission is most frequent during the first 7 to 10 days following rash onset.⁽¹⁾

Close contact⁽¹⁾ is defined as any face-to-face contact (≤ 6.5 feet) with a smallpox case, or having spent at least 3 hours in the same room with someone who has smallpox.

The most common sequelae from smallpox are pockmarks, which may occur all over the body, but are usually most profuse on the face due to the large number of infected sebaceous glands. Blindness can occur when malnutrition or a bacterial infection are present. Complications of smallpox might also include encephalitis, osteomyelitis, stillbirths, or spontaneous abortions. The virus does not persist in the body after recovery.

For a complete description of smallpox, including control measures, refer to the references and web sites listed at the end of this document.

Case Definition

Clinical case definition

An illness with acute onset of fever $\geq 101^{\circ}\text{F}$ (38.3°C) followed by a rash characterized by firm, deep-seated vesicles or pustules in the same stage of development without other apparent cause.

Laboratory criteria for confirmation

1. Polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen, or
2. Isolation of smallpox (variola) virus from a clinical specimen, with variola PCR confirmation. (Level D laboratory only).

Note: Orthopox PCR and negative stain electron microscopy (EM) identification of a pox virus in a clinical specimen suggest an orthopox virus infection, but are not diagnostic of variola and/or vaccinia.


Case Classification


Confirmed: A case of smallpox that is laboratory confirmed, or a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case.


Probable case: A case that meets the clinical case definition, or a case that has an atypical presentation that has an epidemiological link to a confirmed case of smallpox. Examples of atypical presentations of smallpox are: a) hemorrhagic type, b) flat type, c) variola sine eruptione, and d) modified type.

Suspect case: A case with a febrile rash illness with fever preceding development of rash by 1-4 days.

Note: The current case definition provides a high level of specificity, rather than sensitivity. In the event of a smallpox outbreak, the case definition may be modified to increase sensitivity.

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Smallpox Disease Progression	
Incubation Period (Duration: 7 to 17 days) Not contagious	Exposure to the virus is followed by an incubation period during which people do not have any symptoms and may feel fine. This incubation period averages about 12 to 14 days but can range from 7 to 17 days. During this time, people are not contagious.
Initial Symptoms (Prodrome) (Duration: 2 to 4 days) Sometimes contagious	The first symptoms of smallpox include fever, malaise, head and body aches, and sometimes vomiting. The fever is usually high, in the range of 101 to 104 degrees Fahrenheit. At this time, people are usually too sick to carry on their normal activities. This is called the <i>prodrome</i> phase and may last for 2 to 4 days.
Early Rash (Duration: about 4 days) Most contagious Rash distribution: 	<p>A rash emerges first as small red spots on the tongue and in the mouth.</p> <p>These spots develop into sores that break open and spread large amounts of the virus into the mouth and throat. At this time, the person becomes most contagious.</p> <p>Around the time the sores in the mouth break down, a rash appears on the skin, starting on the face and spreading to the arms and legs and then to the hands and feet. Usually the rash spreads to all parts of the body within 24 hours. As the rash appears, the fever usually falls and the person may start to feel better.</p> <p>By the third day of the rash, the rash becomes raised bumps.</p> <p>By the fourth day, the bumps fill with a thick, opaque fluid and often have a depression in the center that looks like a bellybutton. (This is a major distinguishing characteristic of smallpox.)</p> <p>Fever often will rise again at this time and remain high until scabs form over the bumps.</p>
Pustular Rash (Duration: about 5 days) Contagious	The bumps become pustules —sharply raised, usually round and firm to the touch as if there’s a small round object under the skin. People often say the bumps feel like BB pellets embedded in the skin.
Pustules and Scabs (Duration: about 5 days) Contagious	<p>The pustules begin to form a crust and then scab.</p> <p>By the end of the second week after the rash appears, most of the sores have scabbed over.</p>

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Resolving Scabs (Duration: about 6 days) <i>Contagious</i>	<p>The scabs begin to fall off; leaving marks on the skin that eventually become pitted scars. Most scabs will have fallen off three weeks after the rash appears.</p> <p>The person is contagious to others until all of the scabs have fallen off.</p>
Scabs resolved <i>Not contagious</i>	Scabs have fallen off. Person is no longer contagious.

The lesions appear first on the buccal and pharyngeal mucosa, then the face, forearms, and hands. The rash spreads down and within a day or so the extremities and trunk are involved, including the palms and soles. The back is typically more involved than the abdomen. Ultimately, the distribution of the rash is more centrifugal: most profuse on the face, more abundant on the forearms than the upper arms, on the lower legs more so than on the thighs. The lesions are at the same stage of development and approximately the same size in a given area.

The most likely condition to consider in the differential diagnosis of a vesiculopustular rash is varicella (chickenpox). In comparison to smallpox, the lesions of chickenpox commonly occur in successive crops with several stages of maturity present at the same time. The chickenpox rash is more abundant on covered than on exposed parts of the body and appears first on the trunk. The lesions of chickenpox are superficial, whereas those of smallpox are more deep-seated and often involve sebaceous glands and scarring of the pitted lesions. Smallpox lesions are virtually never seen at the apex of the axilla.

Information Needed for Investigation:

Verify the diagnosis. What are the patient's clinical signs and symptoms, and how did they develop over time? What laboratory tests were conducted? What are the results? Have standard, contact, and airborne precautions been instituted?

Establish the extent of illness. Determine if household or other close contacts are, or have been ill by contacting the patient, health care provider, or family members. Do other persons in the community have a similar illness? Characterize information by person, place, and time.


Note: *Persons conducting face-to-face interviews with suspected cases of smallpox should have previously been vaccinated for smallpox, and must wear an N95 or higher respirator, gloves, and gown.*

Determine the source of infection to prevent other cases.

Isolation. Have the smallpox case(s) and contacts been isolated to prevent the spread of the illness?

Notification and Control Measures:

- **Contact the Senior Epidemiology Specialist for the region, or the Department of Health and Senior Service's Situation Room (DSR) at 800-392-0272 (24/7) immediately upon learning of a suspected case of smallpox.**
- Contact the Bureau of Child Care (573-751-2450) if cases are associated with a childcare facility.


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- Contact the Section for Long-term Care Regulation (573-526-0721) if cases are associated with a long-term care facility.
- Contact the Bureau of Health Facility Regulation (573-751- 6303) if cases are associated with a hospital or hospital-based long-term care facility.

Control Measures

General:

- Consider postponement of large public gatherings, and closing of certain facilities.
- Control of smallpox is largely based on immunization, and the appropriate quarantine of contacts, and the isolation of confirmed and suspected cases. The Department of Health and Senior Services will notify CDC for the release and subsequent administration of vaccine if deemed necessary. All contacts should be offered smallpox vaccine and generally advised to take the vaccine regardless of medical conditions. They should also be monitored for 18 days to see if they develop any signs and symptoms of smallpox or 14 days following a successful vaccination.
 - Please refer to the *Missouri Department of Health and Senior Services, Center for Emergency Response and Terrorism, Post-event Smallpox Vaccination Plan (7/03)*. (The *Post-event Smallpox Vaccination Plan* is maintained by the Center for Emergency Response and Terrorism. The Plan is deemed confidential, and will be released for distribution as needed).
- CDC has stated that vaccination within 3 days of exposure will completely prevent or significantly modify smallpox in the vast majority of persons, and vaccination 4–7 days after exposure likely offers some protection from disease or may modify the severity of the disease.⁽⁵⁾
- Isolation of suspected or confirmed cases of smallpox may be accomplished in the home, which is the preferred location, or in facilities designated for the care of smallpox cases, or in a hospital. Circumstances at the particular time and location would determine the best location. The goal of isolation is to prevent the spread of the illness from the infectious person to those who are susceptible while at the same time, providing the appropriate types of care.
- Care should be provided by persons who have been immunized. Susceptible (non-immune) persons should not remain in the home where a possible or confirmed case of smallpox is being cared for.
- Please refer to “Guide A-Smallpox Surveillance and Case Reporting; Contact Identification, Tracing, Vaccination, and Surveillance; and Epidemiologic Investigation” located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-a.pdf> (9/03).
- Please refer to “Guide C - Infection Control Measures for Healthcare and Community Settings and Quarantine Guidelines” of CDC’s Smallpox Response Plan and Guidelines located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-c-part-1.pdf> and <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-c-part-2.pdf> (9/03).
- When providing care to the patient with smallpox, special precautions should be taken when handling soiled clothing, bed linens, etc., please refer to “Guide F - Environmental Control of Smallpox Virus” of CDC’s Smallpox Response Plan and Guidelines located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-f.pdf> (9/03).

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Hospital:⁽³⁾

- Use standard, contact, and airborne precautions.
- On admission alert hospital infection control.
- Patient should be placed in private airborne infection isolation room equipped with negative pressure ventilation with high-efficiency particulate filtration.
- Anyone entering the room must wear an N95 or higher respirator, gloves, and gown, even if there is a history of recent successful immunization.^(1,3)
- Rooms vacated by patients should be decontaminated using standard hospital disinfectants.
- Laundry and waste should be discarded into biohazard bags and autoclaved, bedding, and clothing should be laundered in hot water with laundry detergent followed by hot air drying, or incinerated.
- Cidofovir is a possibility for treatment; the drug must be administered intravenously and is associated with significant renal toxicity.
- Please refer to “Guide C - Infection Control Measures for Healthcare and Community Settings and Quarantine Guidelines” of CDC’s Smallpox Response Plan and Guidelines located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-c-part-1.pdf> and <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-c-part-2.pdf> (9/03).
- Please refer to “Guide F - Environmental Control of Smallpox Virus” of CDC’s Smallpox Response Plan and Guidelines located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-f.pdf> (9/03).

Diagnostic Procedures:

CDC has developed criteria that can be used to evaluate suspected smallpox cases and to categorize patients into high, moderate or low risk for smallpox using major and minor diagnostic criteria.

These criteria will be used when deciding whether to send clinical specimens to CDC for testing.


Note: *All persons presenting with acute generalized vesicular or pustular rash illness should have contact and airborne precautions instituted immediately, before a determination of risk for smallpox is made.*⁽¹⁾

There are 3 major smallpox criteria:

1. Febrile prodrome (fever ≥ 101 degrees F) 1-4 days before rash onset and at least one of the following systemic complaints: prostration, headache, backache, chills, vomiting or severe abdominal pain;
2. Rash lesions are deep in the skin, firm or hard to the touch, round and well-circumscribed, and may become umbilicated or confluent as they evolve;
3. On any one part of the body all the lesions are in the same stage of development (i.e., all are vesicles or all are pustules).

There are five minor smallpox criteria:

1. The distribution of the rash is centrifugal (*i.e.*, the greatest concentration of lesions is on the face and distal extremities with relative sparing of the trunk);
2. The first lesions of the rash appeared on the oral mucosa or palate, or on the face or forearms;

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3. The patient appears toxic or moribund;
4. Lesions progressed slowly (*i.e.*, the individual lesions evolved from macules to papules to pustules; each stage lasts 1-2 days);
5. Lesions on the palms or soles.

A person is considered as **high risk** for smallpox if he or she meets all three major criteria. Immediate action should be taken to make sure that contact precautions and airborne precautions are in place. These patients should be reported to local and/or state health authorities immediately. Obtain digital photographs if possible and consult with dermatology and/or infectious disease experts. Following such consultation, if the patient is still considered to be high risk, the state health department will immediately report the case to CDC and arrangements will be made for laboratory testing for smallpox virus.


A person considered at **moderate risk** of smallpox must have a febrile prodrome and either one other major criterion or ≥ 4 minor criteria. Immediate action should be taken to make sure that contact precautions and airborne precautions are in place. These patients should be reported to local and/or state health authorities immediately. These patients should be evaluated urgently to determine the cause of the illness. Persons classified as high or moderate risk should be seen in consultation with a specialist in infectious diseases and/or dermatology whenever possible. Any person who did not have a febrile prodrome is considered **low risk**, as are persons who had a febrile prodrome, no major criteria, and 4 minor criteria. These patients should be managed as clinically indicated.

For a patient who meets the criteria for moderate risk, the most important laboratory procedure is rapid diagnostic testing for varicella zoster virus (which can be performed at the State Public Health Laboratory).

Variola diagnostic testing is conducted only at the Centers for Disease Control and Prevention (CDC), but may be expanded to other laboratories in the future. If a patient is suspected of having smallpox, the **Department of Health and Senior Services (DHSS) should be alerted at once (800-392-0272)**. Patients classified as high risk of having smallpox (see above) will trigger a rapid response with a CDC team deployed to obtain specimens and advise on clinical management (provided resources are available). **Note:** If clinical specimens are to be sent to CDC for smallpox testing, DHSS must be involved in the review and approval of the testing.

For detailed variola specimen collection and transport information, please refer to “Guide D - Specimen Collection and Transport Guidelines” of CDC’s Smallpox Response Plan and Guidelines located at: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-d.pdf> (9/03).

Comment: The importance of case confirmation using laboratory diagnostic tests differs depending on the epidemiological situation. Laboratory confirmation is important for a first case in a geographic area, leading to release of vaccine as part of the response. In a setting where multiple cases are identified, laboratory capacity may soon be overwhelmed. In such instances, priority for

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laboratory resources will include 1) testing of clinical or environmental specimens that will provide information about a potential source of exposure, facilitating law enforcement activities and case detection; and 2) testing of clinical specimens from cases with an unclear presentation but who are suspected as cases following expert consultation.

Assessment Tools for Evaluating Patients for Smallpox

For all cases, complete the CDC worksheet, “Evaluating Patients for Smallpox”

http://www.dhss.state.mo.us/Lab/bt/Smpox_Wksht.pdf (9/03) and fax the form to the DHSS at the following fax number: (573-526-8389).

A flow chart titled, “Generalized Vesicular or Pustular Rash Illness Protocol” that depicts CDC’s criteria to evaluate suspected smallpox cases and to categorize patients into high, moderate or low risk for smallpox using major and minor diagnostic criteria can be located on the web at:

<http://www.bt.cdc.gov/documentsapp/smallpox/rpg/annex/annex-4-rash-color.pdf> (9/03).

In addition to the above, you can also evaluate a suspicious rash illness for smallpox at the following web site: CDC. Public Health Emergency Preparedness & Response Smallpox, “Evaluate a Rash Illness Suspicious for Smallpox,”

<http://www.bt.cdc.gov/agent/smallpox/diagnosis/riskalgorithm/index.asp>.


Digital photographs of the rash may be sent by e-mail to the DHSS (mail to: DRMS@dhss.mo.gov) for review by a department physician. Consultation with physicians at CDC may also be obtained. Persons taking the pictures should be vaccinated for smallpox. If possible, obtain written consent (**form attached**), for digital photograph(s) to be taken of the patient.

Reporting Requirements

THIS IS A PUBLIC HEALTH EMERGENCY AND WOULD SIGNIFY A BIOTERRORISM EVENT. Immediate notification by telephone is needed if smallpox is suspected.

Smallpox is a Category I (b) disease, for reporting purposes, **DHSS may be contacted 24 hours a day, 7 days a week at (800) 392-0272.**

- For all cases, complete a “**Disease Case Report**” (CD-1) and complete the CDC worksheet, “**Evaluating Patients for Smallpox**” http://www.dhss.state.mo.us/Lab/bt/Smpox_Wksht.pdf (9/03) and fax the forms to the DHSS at the following fax number: (573-526-8389).
- Complete the following secondary investigation forms as needed, or as requested.
 - CDC Form 1: **[Smallpox Post-Event Surveillance Form](#)**
 - CDC Form 2A: **[Smallpox Case Travel/Activity Worksheet -Infectious Period](#)**
 - CDC Form 2B: **[Smallpox Primary Contact/Site Worksheet](#)**
 - CDC Form 2C: **[Smallpox Case Transportation Worksheet – Infectious Period](#)**
 - CDC Form 2D: **[Smallpox Contact Tracing Form](#)**
 - CDC Form 2E: **[Smallpox Case Household and Primary Contact Surveillance Form](#)**
 - CDC Form 2F: **[Smallpox Case Primary Contact’s Household Members Surveillance Form](#)**
 - CDC Form 3A: **[Smallpox Case Exposure Investigation Form](#)**
 - CDC Form 3B: **[Smallpox Case Travel/Activity Worksheet – Exposure Period](#)**

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CDC Form 3C: **Smallpox Case Transportation Worksheet – Exposure Period**


3. Send the completed secondary investigation form(s) to the Regional Health Office.
4. Within 90 days from the conclusion of the investigation, submit the final outbreak report to the Regional Communicable Disease Coordinator.
 - The secondary investigation forms may be reviewed at the following web site: CDC. Public Health Emergency Preparedness & Response, Smallpox, “Smallpox Response Plan and Guidelines” <http://www.bt.cdc.gov/agent/smallpox/response-plan/> (9/03).
 - To obtain the document, “**Forms Overview**” of CDC’s Smallpox Response Plan and Guidelines, that describes the purpose of each of the CDC forms, go to: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-a-forms-overview.pdf> (9/03).
 - To obtain the document, “**Complete Workflow with Forms**,” of CDC’s Smallpox Response Plan and Guidelines, go to: <http://www.bt.cdc.gov/agent/smallpox/response-plan/files/complete-workflow.pdf> (9/03).

References:

1. CDC. Public Health Emergency Preparedness & Response, Smallpox, “Smallpox Response Plan and Guidelines,” <http://www.bt.cdc.gov/agent/smallpox/response-plan/index.asp> (9/03).
2. Chin, James, ed. “Smallpox.” Control of Communicable Diseases Manual, 17th ed. Washington, DC: American Public Health Association, 2000: 455-457.
3. American Academy of Pediatrics. “Smallpox (Variola)” In: Pickering, LK, ed. Red Book: 2003 Report of the Committee on Infectious Diseases. 26th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2003: 554-558.
4. W. Atkinson, C. Wolfe, (Eds.) “Smallpox” Epidemiology and Prevention of Vaccine-Preventable Diseases, 7th ed. CDC 2002. 230 – 250.
www.cdc.gov/nip/publications/pink/smallpox.pdf (9/03).
5. CDC. Public Health Emergency Preparedness & Response, Smallpox, “Smallpox Questions and Answers: The Disease and the Vaccine,”
<http://www.bt.cdc.gov/agent/smallpox/overview/faq.asp - vaccine> (9/03).

Additional References:

1. USAMRIID, Medical Management of Biological Casualties Handbook (4th ed.), February 2001.
<http://www.usamriid.army.mil/education/bluebook.html> (9/03).
2. Association for Professionals in Infection Control/CDC “Bioterrorism Readiness Plan: A Template for Healthcare Facilities.” April 1999.
<http://www.cdc.gov/ncidod/hip/Bio/13apr99APIC-CDCBioterrorism.PDF> (9/03).
3. CDC’s MMWR, February 21, 2003 / Vol. 52 / No. RR-4, “Smallpox Vaccination and Adverse Reactions, Guidance for Clinician”
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5204a1.htm> (9/03).
4. CDC’s MMWR, April 4, 2003 / Vol. 52 / No. RR-7, “Recommendations for Using Smallpox Vaccine in a Pre-Event Vaccination Program, Supplemental Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Healthcare Infection Control Practices

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Advisory Committee (HICPAC)” <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5207a1.htm> (9/03).

5. CDC’s MMWR, June 22, 2001 / Vol. 50 / No. RR-10; 1-25, “Vaccinia (Smallpox) Vaccine, Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2001” <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5010a1.htm> (9/03).

Web Sites:

1. DHSS, Emergency / Terrorism Response, Information for Medical and Public Health Professionals, Selected References, “Smallpox” http://www.dhss.state.mo.us/BT_Response/MedicalProfessionals.htm - Smallpox (9/03).
2. World Health Organization slide set on the diagnosis of smallpox <http://www.who.int/emc/diseases/smallpox/slideset/index.htm> (9/03).
3. CDC. Public Health Emergency Preparedness & Response, “Smallpox” www.bt.cdc.gov/agent/smallpox/index.asp (9/03).
4. CDC. Public Health Emergency Preparedness & Response, Smallpox, “Resource Kit: Materials for Health Professionals” <http://www.bt.cdc.gov/agent/smallpox/reference/resource-kit.asp> (9/03).
5. DHSS, State Public Health Laboratory, Smallpox Virus <http://www.dhss.state.mo.us/Lab/bt/Smallpoxfs.htm> (9/03).

SMALLPOX

(Variola)

FACT SHEET

What are the symptoms of smallpox?

The symptoms of smallpox begin with high fever, head and body aches, and sometimes vomiting. A rash follows that spreads and progresses to raised bumps and pus-filled blisters that crust, scab, and fall off after about three weeks, leaving a pitted scar.

If someone comes in contact with smallpox and is infected, how long does it take to show symptoms?

After exposure, it takes between 7 and 17 days for symptoms of smallpox to appear (average time is 12 to 14 days). During this time, the infected person feels fine and is not contagious.

Is smallpox fatal?

The majority of patients with smallpox recover, but death may occur in up to 30% of cases. Many smallpox survivors have permanent scars over large areas of their body, especially their face. Some are left blind.

How is smallpox spread?

Smallpox normally spreads from contact with infected persons. Generally, direct (<6.5 feet) and fairly prolonged face-to-face contact is required to spread smallpox from one person to another. Smallpox also can be spread through direct contact with infected bodily fluids or contaminated objects such as bedding or clothing. Indirect spread is less common. Smallpox rarely has been spread by virus carried in the air in enclosed settings such as buildings, buses, and trains. Smallpox is not known to be transmitted by insects or animals.

If smallpox virus is released in aerosol form, how long does it survive?

The smallpox virus is fragile. If an aerosol release of smallpox occurs, 90% of virus matter will be inactivated or dissipated in about 24 hours.

How many people would have to get smallpox before it is considered an outbreak?

One confirmed case of smallpox is considered a public health emergency.

How long could an infected person spread smallpox?

Infected persons can spread the disease from the time of development of the earliest lesions to the disappearance of all scabs, about 3 weeks. After having this disease, a person will not get it again.

Is there any treatment for smallpox?

Smallpox can be prevented through use of the smallpox vaccine. There is no proven treatment for smallpox, but research to evaluate new antiviral agents is ongoing. Early results from laboratory studies suggest that the drug cidofovir may fight against the smallpox virus. Studies with animals are currently being done to better understand the drug's ability to treat smallpox disease (the use of cidofovir to treat smallpox or smallpox vaccine reactions are being evaluated and monitored by experts at the National Institutes of Health and CDC). Patients with smallpox can benefit from supportive therapy (e.g., intravenous fluids and medicine to control fever or pain) and antibiotics for any secondary bacterial infections that may occur.

How is smallpox diagnosed?

Smallpox is diagnosed by laboratory tests that detect the virus (e.g. isolation of smallpox (variola) virus from a clinical specimen, or polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen).

Additional information on smallpox is available on the following web sites:

APIC recommendations on use of Smallpox vaccine, 2001

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5010a1.htm> (9/03).

DHSS, Emergency / Terrorism Response, Information for Medical and Public Health Professionals, Selected References, "Smallpox"

http://www.dhss.state.mo.us/BT_Response/MedicalProfessionals.htm - Smallpox (9/03).

St. Louis University clinical fact sheet on Smallpox

http://www.slu.edu/colleges/sph/bioterrorism/quick/smallpox_ref.htm (9/03).

**Missouri Department of Health & Senior Services
Section of Communicable Disease Prevention
Phone: (866) 628-9891 or (573) 751-6113**

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

Division of Environmental Health & Communicable Disease Prevention

Regions for Statewide Disease Investigation / Terrorism Response



Patrick Franklin, ES* (816) 350-5442

Northwest Region Health Office

3717 S. Whitney Ave.

Independence, MO 64055

(816) 350-7691 FAX

TB Control

Lynn Tension, RN (573) 840-9733

(573) 840-9727 FAX

C. Jon Hinkle, SES (816) 632-7276

Cameron Area Health Office

207 East McElwain

Cameron, MO 64429

(816) 632-1636 FAX



Barbara Wolkoff, SES (573) 526-3613

Jo Ann Rudroff, ES* (573) 751-6309

Central Region Health Office

930 Wildwood

Jefferson City, MO 65109

(573) 526-0235 FAX

TB Control

David Oeser (573) 751-6411

statewide alternate for TB

(573) 526-0235 FAX



Doug Dodson, SES (314) 877-2830

Cindy Butler, SES* (314) 877-2857

Eastern Region Health Office

220 South Jefferson

St. Louis, MO 63103

(314) 877-2882 FAX

TB Control

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(573) 840-9727 FAX



Diane Smith, RN, SES (417) 895-6945

Ray Van Ostran, ES* (417) 895-6931

Southwest Region Health Office

1414 West Elfindale

Springfield, MO 65807

(417) 895-6975 FAX

TB Control

Lynn Tension, RN (573) 840-9733

(573) 840-9727 FAX



Sharon Merideth, RN, SES (573) 840-9108

Vacant Position (573) 840-9734

Southeast Region Health Office

2875 James Boulevard

Poplar Bluff, MO 63901

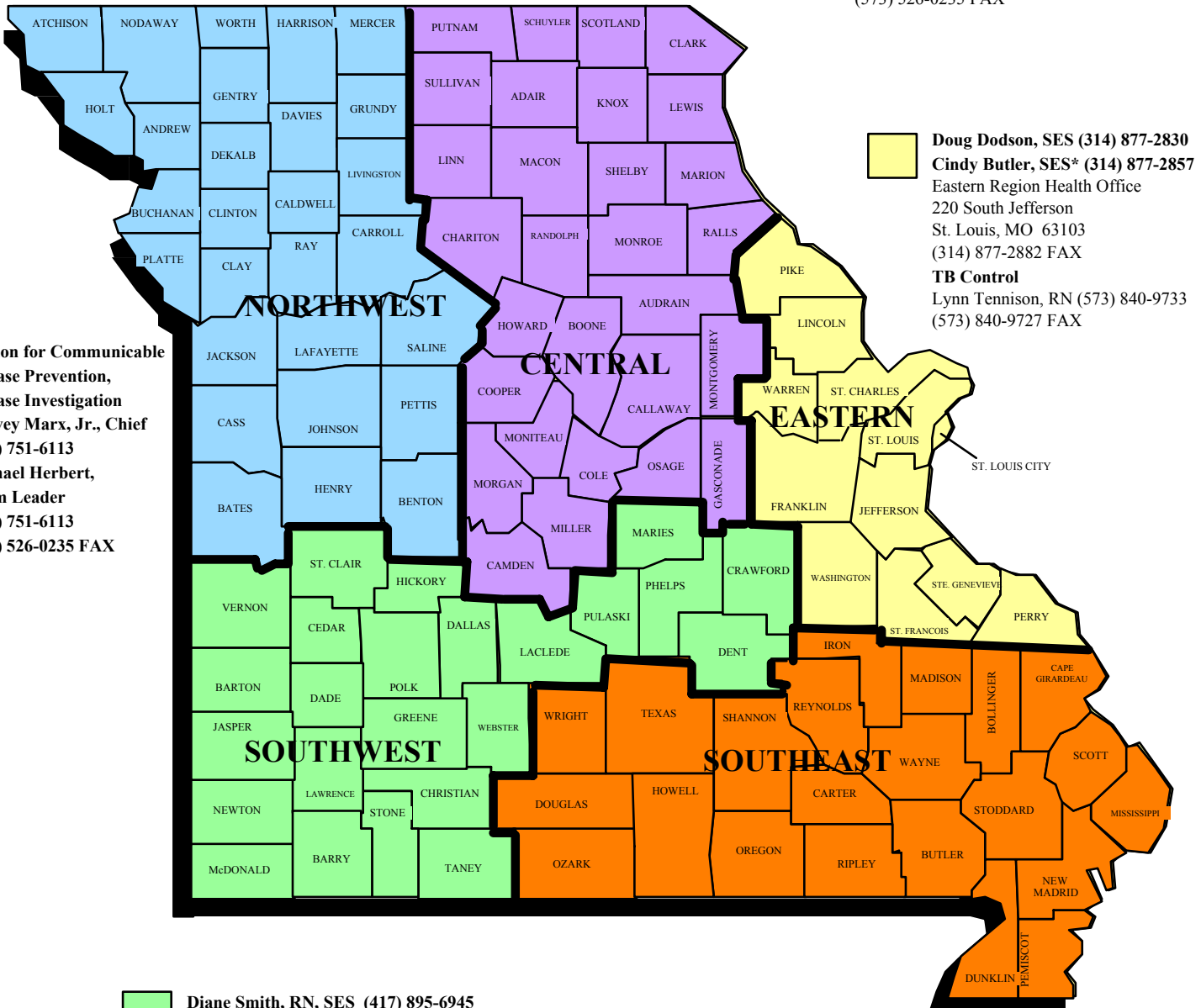
(573) 840-9727 FAX

TB Control

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(573) 840-9727 FAX

**Section for Communicable
Disease Prevention,
Disease Investigation
Harvey Marx, Jr., Chief
(573) 751-6113
Michael Herbert,
Team Leader
(573) 751-6113
(573) 526-0235 FAX**



Asterisk (*) denotes Regional Communicable Disease Coordinator

Return to Smallpox



Missouri Department of Health and Senior Services

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010

Richard C. Dunn
Director



Bob Holden
Governor

I give permission for (print name of person being photographed) to be photographed by a representative of the Missouri Department of Health and Senior Services as part of an epidemiological investigation. The photographs will be treated as a medical record and will not be released to anyone without consent, unless otherwise authorized by law.

Signed _____ Date _____

If signed by someone other than person listed above,

Print name _____

And state relationship _____

Witness signature _____ Date _____

I give permission for (print name of person being photographed) to be photographed by a representative of the Missouri Department of Health and Senior Services as part of an epidemiological investigation. The photographs will be treated as a medical record and will not be released to anyone without consent, unless otherwise authorized by law.

Signed _____ Date _____

If signed by someone other than person listed above,

Print name _____

And state relationship _____

Witness signature _____ Date _____

www.dhss.state.mo.us

The Missouri Department of Health and Senior Services protects and promotes quality of life and health for all Missourians by developing and implementing programs and systems that provide: information and education, effective regulation and oversight, quality services, and surveillance of diseases and conditions.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DISEASE CASE REPORT

REPORT TO LOCAL PUBLIC HEALTH AGENCY

1 DATE OF REPORT ____ / ____ / ____		2 DATE RECEIVED BY LOCAL HEALTH AGENCY ____ / ____ / ____	
3 NAME (LAST, FIRST, M.I.)	4 GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	5 DATE OF BIRTH ____ / ____ / ____	6 AGE
8 RACE (CHECK ALL THAT APPLY) <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> UNKNOWN		9 PATIENT'S COUNTRY OF ORIGIN	
11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		12 COUNTY OF RESIDENCE	13 TELEPHONE NUMBER ()
14 PREGNANT <input type="checkbox"/> YES (IF YES NUMBER OF WEEKS ____) <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		15 PARENT OR GUARDIAN	
16 RECENT TRAVEL OUTSIDE OF MISSOURI OR USA <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE _____		17 DATE OF RETURN ____ / ____ / ____	

18 OCCUPATION		19 SCHOOL/DAY CARE/WORKPLACE		ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	
20 WORK TELEPHONE NUMBER ()		21 OTHER ASSOCIATED CASES <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN IS REPORT PART OF AN OUTBREAK <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		22 TYPE OF COMPLAINT/OUTBREAK <input type="checkbox"/> FOODBORNE <input type="checkbox"/> WATERBORNE <input type="checkbox"/> OTHER (SPECIFY) _____	
23 WAS PATIENT HOSPITALIZED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		24 PATIENT RESIDE IN NURSING HOME <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		25 PATIENT DIED OF THIS ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):		PATIENT		HHLD MEMBER	
		YES NO UNK		YES NO UNK	
27 NAME OF HOSPITAL/NURSING HOME		IS A FOOD HANDLER			
28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER			
29 REPORTER NAME		30 TELEPHONE NUMBER ()		IS A HEALTH CARE WORKER	
31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		32 TYPE OF REPORTER/SUBMITTER <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OUTPATIENT CLINIC <input type="checkbox"/> PUBLIC HEALTH CLINIC <input type="checkbox"/> HOSPITAL <input type="checkbox"/> LABORATORY <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER _____			
33 ATTENDING PHYSICIAN/CLINIC NAME		ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		34 TELEPHONE NUMBER ()	

35 DISEASE NAME(S)	36 ONSET DATE(S) ____ / ____ / ____ ____ / ____ / ____	37 DIAGNOSIS DATE(S) ____ / ____ / ____ ____ / ____ / ____	38 DISEASE STAGE/ RISK FACTOR	39 PREVIOUS DISEASE/STAGE	40 PREVIOUS DISEASE DATE(S) ____ / ____ / ____ ____ / ____ / ____
---------------------------	---	---	--------------------------------------	----------------------------------	--

TEST DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE	COLLECTION DATE (MO/DAY/YR)	QUALITATIVE / QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)

TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (LIST CITY, STATE)

SYMPTOM (IF APPLICABLE)	SYMPTOM SITE (IF APPLICABLE)	SYMPTOM ONSET DATE (MO/DAY/YR)	SYMPTOM DURATION (IN DAYS)

44 COMMENTS

41 - DIAGNOSTICS

42 - TREATMENTS

43 - SYMPTOMS

NOTES FOR ALL RELEVANT SECTIONS:

- Stages, risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a more complete listing, please go to <http://www.dhss.state.mo.us/Diseases/DDwelcome.htm>. You may also contact the Office of Surveillance at 1-800-392-0272 for additional information or to report a case.
- All dates should be in Mo/Day/Year (01/01/2001) format.
- All complete addresses should include city, state and zip code.
- Required fields referenced below are italicized and bold, however fill form as complete as possible.

(1) **Date of Report** -- date sent by submitter of document.

(2) Date received will be filled in by receiving agency.

(3-8) **CASE DEMOGRAPHICS/IDENTIFIERS:** *Last name, First Name*, Gender, *Date of Birth*, Hispanic, Race - please check all that apply

(23) Was patient hospitalized due to this illness?

(32) Type of reporter/submitter (doctor, nursing home, hospital, laboratory) (33-34) Attending physician or clinic (full physician name and degree, address, phone)

DISEASE: (35) *Disease name or name(s)*, (36) *Onset date(s)*, (37) *Diagnosis Date(s)*

(38) Disease Stage or Risk Factor**Syphilis**

Primary (chancre present)
Secondary (skin lesions, rash)
Early Latent (asymptomatic < 1 year)
Late Latent (over 1 year duration)
Neurosyphilis
Cardiovascular
Congenital
Other

Gonorrhea or Chlamydia

Asymptomatic
Uncomplicated urogenital (urethritis, cervicitis)
Salpingitis (PID)
Ophthalmia/conjunctivitis
Other (arthritis, skin lesions, etc)

TB Infection

Contact to TB case
Immunocompromised
Abnormal CXR
Foreigner/Immigrant
IV Drug/Alcohol Abuse
Resident, correctional
Employee, correctional
Over 70
Homeless
Diabetes
Healthcare worker
Converter/2 yrs ≥ 10
Converter/2 yrs ≥ 15

(39) *Previous Disease/Stage (if applicable)* (40) *Previous Disease Dates (if applicable)*

(41) Diagnostics (Please Attach Lab Slip)**Test Type****Hepatitis**

Igm Anti-HBc
Anti-HBs
Anti-HBc Total
Igm Anti-HAV
HBsAg
Hep C

TB

Not Done
Mantoux
Multiple puncture device
X-Ray
Smear
Culture

Other

Elisa
Western Blot
Culture
ALT
AST

Specimen Type (blood, urine, CSF, smear, swab), **Collection Date** (Mo/Day/Yr), **Qualitative** (negative, positive, reactive), **Quantitative Results** (1:1, 2.0 mm reading,) **Reference Range** (1:1neg, 1:64 equivocal, 1:128 positive, > 2 positive), **Laboratory** (name, address)

(42) TREATMENT**Reason not treated**

False positive
Previous treated
Age

Drug**TB**

Isoniazid
Ethambutol
Pyrazinamide
Rifampin

(43) SYMPTOMS:

Symptom (jaundice, fever, dark urine, headache) **Symptom Site** (head, liver, lungs, skin), **Symptom Onset Date** (Mo/Day/Yr) and **Symptom Duration** (in days)

(44) **Comments:** Attach additional sheets if more comments needed.

WORKSHEET: EVALUATING PATIENTS FOR SMALLPOX

Identification Number	_____
Person Completing Form	_____
Date of Contact with Case	_____
Today's Date (mo/da/yr)	_____

PATIENT INFORMATION

Name: _____

LAST FIRST MIDDLE INITIAL

Date of Birth: ____/____/____ Age: ____ Sex: ☐ Male ☐ Female

Telephone: _____

Home _____ Other _____

Address: _____

CITY STATE ZIP

Race: ☐ White ☐ Black ☐ Asian ☐ OtherEthnicity: ☐ Hispanic ☐ Non-Hispanic

Country of Birth: _____

Where is the patient now? ☐ Home ☐ Doctor's Office☐ Emergency Room (if checked, continue below)☐ Hospital (if checked, continue below)☐ Other (specify) _____

Hospital Name _____

City/State _____

Admission Date ____/____/____ Discharge Date ____/____/____

Hospital Telephone Number (____) _____

PROVIDER INFORMATION

Name: _____

Patient Population Specialty: _____

Telephone: _____

Type (____) _____

Type (____) _____

E-mail Address: _____

Name: _____

Patient Population Specialty: _____

Telephone: _____

Type (____) _____

Type (____) _____

E-mail Address: _____

CLINICAL INFORMATION

PRODROME / SYMPTOMS 1-4 DAYS BEFORE RASH ONSET

Did the patient have a fever and other illness 1-4 days before rash onset? ☐ Yes ☐ No ☐ Unknown

Date of prodrome onset ____/____/200__

If Yes, on what date did the patient first have a fever? ____/____/____

What was the highest temperature? _____°F or _____°C

On what date: ____/____/____

Check all features of the prodrome that apply:

- | | |
|--|--|
| <input type="checkbox"/> No/Mild prodrome (<1 day) | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sore throat* |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Chills | |
| <input type="checkbox"/> Vomiting | |

*In infants, this may manifest as drooling or refusing to eat or drink.

Was the patient toxic or seriously ill? ☐ Yes ☐ No ☐ UnknownWas the patient able to do most normal activities? ☐ Yes ☐ No ☐ Unknown

RASH

Date of rash onset ____/____/200__

Was the rash acute (sudden) in onset? ☐ Yes ☐ No ☐ UnknownWas a black scar (eschar) present before or at the time of appearance of the rash? ☐ Yes ☐ No ☐ UnknownIs the rash *generalized* (i.e., multiple parts of the body) or *focal* (i.e., only one part of the body)? ☐ Generalized ☐ Focal

Where on the body were the first lesions noted?

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Face | <input type="checkbox"/> Arms |
| <input type="checkbox"/> Trunk | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Inside the mouth | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (specify) _____ | |

Since rash onset, where on the body was the rash most dense?

- | | |
|--|---|
| <input type="checkbox"/> Trunk | <input type="checkbox"/> Equally distributed everywhere |
| <input type="checkbox"/> Face or scalp | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Distal extremities (arms, legs) | |

Are there any lesions on the palms or soles? ☐ Yes ☐ No ☐ Unknown

What kind of lesions does the patient have now? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Macules (flat, reddish spots) | <input type="checkbox"/> Pustules (blisters filled with pus) |
| <input type="checkbox"/> Papules (solid bumps) | <input type="checkbox"/> Crusts |
| <input type="checkbox"/> Vesicles (fluid-filled blisters) | <input type="checkbox"/> Other _____ |

If more than one kind of lesion, which kind of lesion is now the most common? _____

Are the lesions now:

- | |
|--|
| <input type="checkbox"/> Superficial (on top of the skin) |
| <input type="checkbox"/> Deep (feel embedded deeply in the skin) |
| <input type="checkbox"/> Neither (describe) _____ |

How many lesions are present? (in total) _____

If no precise count is available, please estimate:

- | |
|---|
| <input type="checkbox"/> <20 |
| <input type="checkbox"/> 20-50 (able to count in less than a minute) |
| <input type="checkbox"/> 51-499 (typically an average case of varicella has 200-400 lesions) |
| <input type="checkbox"/> >500 (lesions confluent in some places, can't see normal skin between) |

On any one part of the body (e.g., face or arm), are all the lesions in the same state of development? ☐ Yes ☐ No ☐ Unknown

How big are most of the lesions? (Do not measure superinfected lesions.)

- | |
|---|
| <input type="checkbox"/> Small (1-5 mm) |
| <input type="checkbox"/> Large (5-10 mm) |
| <input type="checkbox"/> Neither (describe) _____ |

Have any lesions crusted? ☐ Yes ☐ No ☐ Unknown

If Yes, how many days did it take for the first lesions to crust? _____

How itchy is the rash? ☐ Not at all ☐ Somewhat ☐ Very ☐ UnknownDoes the patient have lymphadenopathy? ☐ Yes ☐ No ☐ Unknown

If Yes, describe: _____

Is the patient toxic or moribund now? ☐ Yes ☐ No ☐ Unknown

If Yes, describe: _____

Continues

CLINICAL NOTES

SOURCE / EXPOSURE INFORMATION

Is chickenpox (varicella) occurring in the community? ☐ Yes ☐ No ☐ Unknown

Has the patient had contact with a person with chickenpox or shingles 10-21 days before rash onset? ☐ Yes ☐ No ☐ Unknown

If Yes, give date(s) and type of contact: _____

Within the past three (3) weeks: *(applies to remainder of section)*

Has the patient been in contact with a person with any other rash illness? ☐ Yes ☐ No ☐ Unknown

If Yes, please specify, with date: _____

Has the patient traveled in this time period before onset of illness? ☐ Yes ☐ No ☐ Unknown

If Yes, please provide locations and dates of travel:

Place: _____ Dates: _____

Place: _____ Dates: _____

Has the patient had contact with mice? ☐ Yes ☐ No ☐ Unknown

Has the patient been camping, hiking, or exposed to woods before onset of illness? ☐ Yes ☐ No ☐ Unknown

If Yes, please provide details and dates:

_____ Dates: _____

_____ Dates: _____

Has the patient received insect bites? ☐ Yes ☐ No ☐ Unknown

Has the patient been exposed to ticks? ☐ Yes ☐ No ☐ Unknown

VACCINATION HISTORY

Has the patient received chickenpox (varicella) vaccine? ☐ Yes ☐ No ☐ Unknown
(Chickenpox vaccine was licensed in the United States in 1995.)

If Yes, dose #1 date ____/____/____ or age _____

dose #2 date ____/____/____ or age _____
(only persons >13 years receive a second dose)

Has the patient ever received smallpox vaccine? ☐ Yes ☐ No ☐ Unknown
(The smallpox vaccine was routinely given in the U.S. until 1972, was recommended for health care providers until 1976, was administered in the military until 1990.)

If Yes, when was the most recent vaccination? ____/____/____
or at what age? _____

MEDICAL HISTORY

Has the patient ever had chickenpox or shingles? ☐ Yes ☐ No ☐ Unknown

If Yes, when? ____/____/____ or at what age? _____

Is the patient immunocompromised? ☐ Yes ☐ No ☐ Unknown

If Yes, specify type of illness *(e.g., cancer, HIV/AIDS)* _____

Does the patient have any other serious underlying medical illnesses? *(e.g., asthma)* ☐ Yes ☐ No ☐ Unknown

If Yes, please list: _____

Is the patient sexually active? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

DIFFERENTIAL DIAGNOSIS

LABORATORY

Have you tested the patient for chickenpox? ☐ Yes ☐ No ☐ Unknown

If Yes, what type of test? _____

Results of tests: _____

Date: ____/____/____

MEDICATIONS

Is the patient on medications that suppress the immune system? *(e.g., steroids, chemotherapy, radiation)* ☐ Yes ☐ No ☐ Unknown

If Yes, name of medication: _____

Dosage: _____

Method of administration: _____

Is the patient taking antiviral medications? ☐ Yes ☐ No ☐ Unknown

If Yes, name of medication: _____

Dosage: _____

Method of administration: _____

Please list all prescription and non-prescription medications that the patient has taken in the past three weeks. *(List drug, dosage, route, dates)*

Is there a history of illicit drug use in the past three weeks? ☐ Yes ☐ No ☐ Unknown

If Yes, please specify drug, amount (if known), route, and dates:

Other lab testing — Please complete last page

Other comments: _____

www.cdc.gov/nip/smallpox

PLEASE LIST ALL LABORATORY TESTS ORDERED OR PERFORMED REGARDING THIS ILLNESS

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: ☐ State _____
☐ Other _____

② **Case #**

Page 1 of 2
Form 1 (Draft 11/26/2002) Version 3.0

Form 1: Smallpox Post-Event Surveillance Form
Please print

State

Case #

CLINICAL COURSE	
41. DATE LAST SCAB FELL OFF: OR CHECK IF UNKNOWN <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
42. DID THE PATIENT DEVELOP ANY COMPLICATIONS: IF YES, CHECK ALL THAT APPLY:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Skin, infected lesions/abscesses <input type="checkbox"/> Corneal ulcer or keratitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Shock <input type="checkbox"/> Bacterial sepsis
43. ANTIVIRAL MEDICATION (CIDOFOVIR): IF YES, DATE CIDOFOVIR STARTED:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
DURATION: _____ DAYS	
44. OTHER ANTIVIRAL MEDICATIONS GIVEN:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, SPECIFY: _____	

CLINICAL OUTCOME	
45. WAS CASE ADMITTED TO HOSPITAL?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, HOSPITAL NAME: _____	
HOSPITAL LOCATION: _____	
DATE ADMITTED:	DATE DISCHARGED:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
46. WAS CASE ADMITTED/TRANSFERRED TO 2 ND HOSPITAL?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, HOSPITAL NAME: _____	
HOSPITAL LOCATION: _____	
DATE ADMITTED:	DATE DISCHARGED:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
47. DID THE PATIENT DIE FROM SMALLPOX ILLNESS OR ANY SMALLPOX COMPLICATIONS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, DATE OF DEATH:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year

LABORATORY	
48. WAS SPECIMEN COLLECTED FOR TESTING:	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
49. WAS LAB TESTING DONE FOR SMALLPOX:	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF QUESTIONS 48 AND 49 ARE "NO" OR "UNKNOWN" THEN GO TO QUESTION 56.	
* Information on specimen collection and testing can be found in the patient's medical chart or provided by the laboratory	

ORTHOPOX GENERIC TESTS			
TEST	DATE	RESULT	WHERE
50. ORTHOPOX PCR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify: _____
51. ELECTRON MICROSCOPY (EM) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Pox Virus Identified <input type="checkbox"/> Pox Virus Not Identified <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify: _____

LABORATORY, CON'T			
VARIOLA SPECIFIC TESTS			
TEST	DATE	RESULT	WHERE
52. VARIOLA PCR FROM CLINICAL SPECIMEN <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify: _____
53. VARIOLA CULTURE WITH VARIOLA PCR CONFIRMATION <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify: _____

VACCINIA SPECIFIC TEST			
TEST	DATE	RESULT	WHERE
54. VACCINIA PCR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify: _____

55. OTHER TESTING PERFORMED: ☐ Yes ☐ No ☐ Unknown
IF YES, SPECIFY: _____

EPIDEMIOLOGIC	
56. TRANSMISSION SETTING:	<input type="checkbox"/> Athletics <input type="checkbox"/> College <input type="checkbox"/> Community <input type="checkbox"/> Daycare <input type="checkbox"/> Dr. Office <input type="checkbox"/> Correctional facility <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Int'l travel <input type="checkbox"/> Military <input type="checkbox"/> School <input type="checkbox"/> Place of worship <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> Unknown
If Other, specify: _____	

CASE CLASSIFICATION	
57. DOES THIS CASE MEET THE CLINICAL CASE DEFINITION:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
58. IS THIS CASE EPIDEMIOLOGICALLY LINKED TO A CONFIRMED CASE:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, NAME/CASE #, IF KNOWN: _____	
59. IS THIS CASE LABORATORY-CONFIRMED:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, BY WHAT METHOD:	<input type="checkbox"/> PCR <input type="checkbox"/> Culture/PCR
60. WHAT IS THE CASE CLASSIFICATION:	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
61. IF NOT SMALLPOX, SPECIFY FINAL DIAGNOSIS: _____	

Smallpox Clinical Case Definition: An illness with acute onset of fever $\geq 101^{\circ}\text{F}$ followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause.

Laboratory Criteria for Confirmation: Polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen; OR Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only).
Note: Orthopox PCR and negative stain electron microscopy (EM) identification of a pox virus in a clinical specimen suggest orthopox virus infection but are not diagnostic of variola and/or vaccinia. (Level D laboratory or approved Level C laboratory)

Level D laboratories include the CDC and USAMRIID. Initial confirmation of a smallpox outbreak requires testing in a Level D laboratory. Level C laboratories will assist with testing of clinical specimens following initial confirmation of an outbreak by CDC.

Smallpox Case Classification:
Confirmed case = A case of smallpox that is laboratory confirmed, OR a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case.
Probable case = A case that meets the clinical case definition, OR a case that has an atypical presentation that has an epidemiological link to a confirmed case of smallpox. Atypical presentations of smallpox are: a) hemorrhagic type, b) flat, type not appearing as typical vesicles nor progressing to pustules and variola sine eruptione.
Suspect case = A case with a febrile rash illness with fever preceding development of rash by 1-4 days.

Form 2A: Smallpox Case Travel/Activity Worksheet - Infectious Period

Please print

OMB NO. 0920-0008

Exp. Date: 06/2003

1. State

2. Case #

3. CASE NAME: Last First Middle / Suffix / Nickname/Alias

4. Interviewer Name: Last First Middle

5. Interview Date: MM / DD / YYYY

6. Date of fever onset: MM / DD / YYYY

F=Fever, R=Rash, C=Cough

RECORD ANY ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

START HERE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C
DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C
DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C
DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C	DATE: <input type="checkbox"/> F <input type="checkbox"/> R <input type="checkbox"/> C

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 2B: Smallpox Primary Contact/Site Worksheet

Please print

1. State

2. Case #

OMB NO. 0920-0008

Exp. Date: 06/2003

3. CASE NAME: _____ / _____ / _____
 Last First Middle Suffix Nickname/Alias

4. Interviewer Name: _____
 Last First Middle

5. Interview Date: ____ / ____ / ____
 MM DD YYYY

6. Date of fever onset: ____ / ____ / ____
 MM DD YYYY

*Contact Priority Category Codes:

1 = (Highest priority) Case household contacts: all immediate family members; others spending ≥ 3 hours in the household since case's onset of rash

2 = Non- household contacts with contact < 6 feet with case with rash for ≥ 3 hours

3 = Non-household contacts with contact < 6 feet with case with rash for < 3 hours

4 = Non-household contacts with contact ≥ 6 feet with case with rash for ≥ 3 hours

5 = Non-household contacts with contact ≥ 6 feet with case with rash for < 3 hours

7. Name of Person (Last, First) and/or Name of Site	8. Date of First Exposure ____/____/____ MM DD YYYY	9. Date of Last Exposure ____/____/____ MM DD YYYY	10. Closest Distance in feet (Circle) <6ft ≥6ft	11. Longest Duration in Hours (Circle) < 3 ≥ 3	12.Contact Priority Category*	13.Form 2D #	14.Notes:
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			
	____/____/____ MM DD YYYY	____/____/____ MM DD YYYY	<6ft ≥6ft	< 3 ≥ 3			

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 2C: Smallpox Case Transportation Worksheet – Infectious Period

Please print

OMB NO. 0920-0008

Exp. Date: 06/2003

1. State

2. Case #

3. CASE NAME: _____ / _____ / _____

4. Interviewer Name: Last First Middle Suffix Nickname/Alias

Last First Middle

5. Interview Date: ____ / ____ / ____
MM DD YYYY

6. Date of fever onset: ____ / ____ / ____
MM DD YYYY

COMPLETE AS MUCH INFORMATION AS POSSIBLE FOR EACH TYPE OF TRANSPORTATION USED BY CASE SINCE FEVER ONSET.

7. Date of Travel	8. Time of Travel (____:____) [AM / PM (Circle)]	9. Transport Type (e.g., bus, train, plane, car)	10. Carrier/Company Name	11. Route/ Flight #	12. Origin City	13. Origin State	14. Origin Country	15. Destination City	16. Destination State	17. Destination Country
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									
____/____/____ MM DD YYYY	____:____ AM / PM									

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 2D: Smallpox Contact Tracing Form

OMB NO. 0920-0008
Exp. Date: 06/2003

1. Last Name: First Name: MI: Suffix: Alias:					2. Street Address: Apt #:														
3. City: State:		4. Zip:		5. DOB:		6. Age (Yrs):		7. Ethnicity:		8. Race - Mark all that apply:		9. Sex:		20. Phone Number - Home:					
<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>					
10. Height:		11. Size/Build:		12. Hair:		13. Complexion:		14. Pregnant?:		15. Primary Language Spoken:		16. English Spoken:		17. Name of Employer/School:					
<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>		<div></div>					
24. Exposure Dates:				25. Reported Case Number:				26. Date Interview of Reported Case:				18. Address of Employer/School:				19. Work Hours:			
Date of First Exposure:				<div></div>				<div></div>											
<div></div>				<div></div>				<div></div>											
Date of Last Exposure:				<div></div>				<div></div>											
<div></div>				<div></div>				<div></div>											
27. Contact Type (Mark One)				28. Priority Code *				30. Location, Epi Notes, and Other Relevant Information:											
Primary Contact																			
OOJ Primary Contact																			
27. (continued)				29. Primary Contact Form 2D Number:				39. Disposition (Select One)											
Secondary Contact				(Complete only for Secondary Contacts)				1. Located											
OOJ Secondary Contact								2. Not Located											
Case Contact Priority Codes * 1 = Highest Priority - Case household contacts: All immediate family members; others spending > 3 hours in the household since case's onset of rash. 2 = Non household contacts with contact <6 feet with Case with rash for >= 3 hours. 3 = Non household contacts with contact <6 feet with Case with rash for < 3 hours. 4 = Non household contacts with contact >= 6 feet with Case with rash for >= 3 hours. 5 = Non household contacts with contact >= 6 feet with Case with rash for < 3 hours.				31. Date Form 2D Initiated:				32. Initiated By:				1A Referred for Vaccination, Fever or Rash or Cough Not Present				2A Unable to Locate			
				<div></div>								1B Referred for Clinical Assessment, Fever or Rash or Cough Present				2B Moved From Jurisdiction, To: _____			
				33. Date of Contact Notification:				34. Notified By:				1C Already Hospitalized as Suspected Case, Fever or Rash or Cough Present				3. Deceased			
				<div></div>								1D Isolated, Not Vaccinated (within last 6 months), Fever or Rash or Cough Not Present				3A Smallpox Suspected			
				35. Disposition Date:				36. Dispo'ed By:				1E Previously Vaccinated (within last 6 months), Fever or Rash or Cough Not Present				3B Unrelated to Smallpox			
<div></div>								Date of Vaccination: <div></div>				4. 4 Other : _____							
37. Follow-up Assignment Date:				38. Follow-up By:				Reported Vaccination <input type="checkbox"/> Major <input type="checkbox"/> None <input type="checkbox"/> Equivocal <input type="checkbox"/> Unknown				40. Smallpox Case ID:							
<div></div>												<div></div>							
Form 2D Number - A0001234				Department of Health and Human Services Centers for Disease Control and Prevention				41. Reviewed By:				42. Comments:							

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0006).

Form 2E: Smallpox Case Household and Primary Contact Surveillance Form

OMB NO. 0920-0008

Exp. Date: 06/2003

Please print

I. CASE INFORMATION (Filled out by interviewer)																					
1. *CASE ID#: _____																					
II. HOUSEHOLD OR PRIMARY CONTACT INFORMATION (Questions marked with (*) to be filled out by interviewer)																					
*2. DATE OF HOUSEHOLD VISIT: ____/____/____ MM DD YYYY																					
*3. NAME OF CASE HOUSEHOLD OR PRIMARY CONTACT: _____ Last First Middle Suffix Nickname/Alias																					
*4. SEX (Circle): Male Female 5. AGE: _____ 6. HOUSEHOLD CONTACT/PRIMARY CONTACT FORM 2D# _____																					
*7. DATE OF LAST EXPOSURE TO CASE: ____/____/____ MM DD YYYY										8. DATE VACCINATED: ____/____/____ MM DD YYYY							9. CALL BACK DATE (7 days after vaccination) ____/____/____ MM DD YYYY				
III. HOUSEHOLD OR PRIMARY CONTACT CLINICAL SIGNS TRACKING (Filled out by Household or Primary Contact)												11. *[Insert telephone number or sticker here]									
10. Record your temperature each day in the boxes below. If fever is 101° F or greater for two consecutive days, call the number provided immediately:																					
Temperature Daily Record	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
12. If rash develops, mark the day the rash started below, and call the number provided:																					
Rash	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
13. If you develop any of the severe vaccine adverse reactions shown on the Vaccination Information Statement, call:												14. *[Insert telephone number or sticker here]									
15. For non-emergencies or if you have questions, call:												16. *[Insert telephone number or sticker here]									

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 2F: Smallpox Case Primary Contact's Household Members Surveillance Form

OMB NO. 0920-0008

Exp. Date: 06/2003

Please print

I. CASE INFORMATION (Filled out by interviewer)

1. *CASE ID#: _____

II. PRIMARY CONTACT INFORMATION (Questions marked with (*) to be filled out by interviewer)

*2. DATE OF HOUSEHOLD VISIT: ____/____/____
MM DD YYYY*3. NAME OF PRIMARY CONTACT: _____/_____/_____
Last First Middle Suffix Nickname/Alias

*4. PRIMARY CONTACT FORM 2D# _____

III. INFORMATION ABOUT PRIMARY CONTACT'S HOUSEHOLD MEMBERS (Filled out by primary contact or household member)

5. *Form 2D #	6. Last name	7. First name	8. MI	9. Sex	10. Date vaccinated	11. Call Back Date
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY
					____/____/____ MM DD YYYY	____/____/____ MM DD YYYY

12. If anyone develops any of the severe vaccine adverse reactions shown on the Vaccination Information Statement, call:

13. *[Insert telephone number or sticker here]

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Case Exposure/Source Information

3. INTERVIEW DATE:

Month Day Year

Case Information

4. CASE NAME: _____ / _____ / _____
(Last) (First) (Middle) (Suffix) (Nickname)5. ADDRESS: _____
Street Address, Apt #. City State Zip Code6. Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Unknown

Information on possible source of infection - INDIVIDUALS

7. DO YOU KNOW FROM WHOM YOU CAUGHT THIS ILLNESS? ☐ Yes ☐ No ☐ Unknown
IF NO OR UNKNOWN, GO TO QUESTION 10.

IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

8. DATE OF LAST EXPOSURE: _____
Month Day Year

9. DID THE PERSON HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS (MARK ALL THAT APPLY):

- ☐ RASH: PAPULES/BUMPS ☐ FEVER ☐ SEVERELY ILL ☐ OTHER, DESCRIBE: _____
☐ RASH: VESICLES ☐ COUGH ☐ IMMOBILE
☐ RASH: PUSTULES (FLUID FILLED)
☐ RASH: CRUSTS/SCABS

10. DO YOU KNOW OF ANY OTHER PERSON WITH AN ILLNESS LIKE YOURS: ☐ Yes ☐ No ☐ Unknown
IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

11. DURING THE DATES FROM _____ TO _____ BEFORE YOUR RASH ONSET, WERE YOU IN CONTACT WITH
(Insert date: 21 days before rash onset) (Insert date: 7 days before rash onset)

DO YOU KNOW OF ANYONE WHO APPEARED TO HAVE:

11a. CHICKENPOX: ☐ Yes ☐ No ☐ Unknown11b. A SEVERE RASH ON THE FACE AND/OR ARMS: ☐ Yes ☐ No ☐ Unknown

IF YES TO 11a OR 11b, GIVE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE INDIVIDUALS:

Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

DATE OF LAST EXPOSURE: _____
Month Day Year

Name (LAST, FIRST) Street Address, Apt #. City State Zip Code Area Code Number

DATE OF LAST EXPOSURE: _____
Month Day Year

Information on possible source of infection - PLACE

12. DO YOU KNOW WHERE YOU CAUGHT THIS ILLNESS? ☐ Yes ☐ No ☐ UnknownIF YES, NAME OF PLACE/EVENT: _____ TYPE OF PLACE/EVENT: _____
(i.e., restaurant, store, theater, sports event, office, etc)ADDRESS / LOCATION: _____
Street Address, Apt #. City State Zip CodeDESCRIBE LOCATION: _____ TELEPHONE: _____
Area Code Number13. POSSIBLE DATE OF EXPOSURE: _____
Month Day Year

14. TIME: _____ AM / PM

15. ESTIMATED NUMBER OF PERSONS POTENTIALLY EXPOSED AT THE SAME PLACE AND TIME AS CASE: _____

LIST OTHERS POTENTIALLY EXPOSED (NAME, ADDRESS, TELEPHONE) ON REVERSE SIDE OF THIS FORM OR ON AN ADDITIONAL PIECE OF PAPER.

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

LIST OF NAMES AND ADDRESSES/TELEPHONE NUMBERS:

Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>
Name/Location	Street Address, Apt #	City	State <input type="text"/>	Zip Code <input type="text"/>	Area Code <input type="text"/>	Number <input type="text"/>

SAMPLE QUESTIONS FOR FORM 3B: SMALLPOX CASE TRAVEL/ACTIVITY WORKSHEET – EXPOSURE PERIOD:

For the next few questions, I'd like you to think back to the 14 day period between 1 and 3 weeks before you developed a rash that we have marked on the calendar. Let's start with weekdays. (Offer dates, holidays, etc., as available to anchor the case's recall to this time period. Consider routine weekday activities in a systematic way going either back from day 7 or forward from day 21 from fever onset depending on what seems easier to do.)

For weekends, ask about usual routines and then occasional activities. Prompt especially for attendance at public events. A question to capture this type of attendance follows after questions regarding usual activities.

WHAT IS YOUR USUAL ROUTINE:DO YOU WORK? ☐ Yes ☐ NoVOLUNTEER ON A REGULAR BASIS? ☐ Yes ☐ NoDO YOU GO TO SCHOOL? ☐ Yes ☐ NoHAVE ANOTHER EVERY DAY ACTIVITY? ☐ Yes ☐ No

DURING THIS 14-DAY PERIOD AS SHOWN ON THIS CALENDAR, DID YOU SPEND ANY TIME REGULARLY (3 OR MORE TIMES A WEEK) IN THE FOLLOWING PLACES?
(Check all that apply.)

WORK: ☐ Yes ☐ NoSCHOOL: ☐ Yes ☐ NoRESTAURANT: ☐ Yes ☐ NoYOUR CHILD'S SCHOOL OR DAY CARE CENTER: ☐ Yes ☐ NoGROCERY STORE: ☐ Yes ☐ NoOTHER, SUCH AS PLACE OF WORSHIP, GYM, ETC: ☐ Yes ☐ No IF YES, SPECIFY: _____**Please complete FORM 3C – CASE EXPOSURE TRANSPORTATION WORKSHEET for all transportation questions.**

IF YOU WORK, GO TO SCHOOL, OR TRANSPORT YOUR CHILDREN OR OTHER FAMILY MEMBERS, HOW DO YOU TRAVEL TO AND FROM THESE PLACES?

CAR ALONE, BICYCLE, WALK: ☐ Yes ☐ No CAR WITH OTHER PEOPLE IN THE VEHICLE AT LEAST SOMETIMES: ☐ Yes ☐ NoBUS, TRAIN OR SUBWAY: ☐ Yes ☐ No TAXI: ☐ Yes ☐ NoOTHER, SPECIFY (E.G. PLANE): ☐ Yes ☐ No IF YES, SPECIFY: _____

NOTE: For regular travel schedule such as to and from work, indicate range of days and times if this is the same each day.

DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU TRAVEL OUT OF TOWN (IF CITY, OUT OF URBAN AREA, IF RURAL, OUT OF COUNTY)? ☐ Yes ☐ No

DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU VISIT ANY OF THE FOLLOWING ACTIVITIES AT LEAST ONCE:

HOTEL/CONVENTION CENTER: ☐ Yes ☐ NoCHURCH, TEMPLE, MOSQUE OR OTHER PLACE OF WORSHIP: ☐ Yes ☐ NoSHOPPING MALL OR LARGE STORE: ☐ Yes ☐ NoDOCTOR'S OFFICE, EMERGENCY ROOM, CLINIC OR HOSPITAL: ☐ Yes ☐ NoAIRPORT: ☐ Yes ☐ NoTHEATER (MOVIES/PLAY): ☐ Yes ☐ NoCONCERT: ☐ Yes ☐ NoPUBLIC SPORTING EVENT: ☐ Yes ☐ NoBUS, TRAIN OR SUBWAY: ☐ Yes ☐ NoFAIR, FESTIVAL OR CARNIVAL: ☐ Yes ☐ NoANY OTHER GATHERING WITH MORE THAN 100 OTHER PEOPLE: ☐ Yes ☐ No IF YES, SPECIFY: _____

Form 3B: Smallpox Case Travel/Activity Worksheet – Exposure Period

Please print

OMB NO. 0920-0008

Exp. Date: 06/2003

1. State

2. Case #

3. CASE NAME: _____ / _____ / _____

Last

First

Middle

Suffix

Nickname/Alias

4. Interviewer Name: _____

Last

First

Middle

5. Interview Date: _____ / _____ / _____

MM

DD

YYYY

6. Date of case fever onset: _____ / _____ / _____

MM

DD

YYYY

RECORD ANY ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:

START HERE

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 3C: Smallpox Case Transportation Worksheet – Exposure Period

Please print

OMB NO. 0920-0008

Exp. Date: 06/2003

1. State

2. Case #

3. CASE NAME: _____ / _____ / _____

Last

First

Middle

Suffix

Nickname/Alias

4. Interviewer Name: _____

Last

First

Middle

5. Interview Date: ____ / ____ / ____

MM

DD

YYYY

6. Date of fever onset: ____ / ____ / ____
MM DD YYYY

COMPLETE AS MUCH INFORMATION AS POSSIBLE FOR EACH TYPE OF TRANSPORTATION USED BY CASE 19 DAYS PRIOR TO FEVER ONSET.

7. Date of Travel	8. Time of Travel (____ : ____) [AM / PM (Circle)]	9. Transport Type (e.g., bus, train, plane, car)	10. Carrier/Company Name	11. Route/ Flight #	12. Origin City	13. Origin State	14. Origin Country	15. Destination City	16. Destination State	17. Destination Country
____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									
____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									
____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									
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____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									
____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									
____ / ____ / ____ MM DD YYYY	____ : ____ AM / PM									

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